

MANAGING HEALTH CARE COSTS

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Highlights and Conclusions

For several years, medical benefit costs showed some signs of stability. Although annual increases in premiums and contributions climbed at a rate several percentage points above general inflation, this seemed no serious cause for alarm. Then came the renewal notices of late 1987 and early 1988. The majority of our respondents who opened their statements at that time saw cost increases averaging from 10 to 20 percent over the prior period.

Without question, health care was costing their companies and their employees dearly. And it would cost even more in the future.

Rather than recite still another litany of rising costs, the current study was designed to show what actions benefits managers are taking to slow the cost escalation. By collecting both rate increase data and information on cost containment activities, we hoped to show some correlations on effectiveness. An analysis of 323 responses to our four-page questionnaire reveals the following:

- Statistical correlations in the data suggest that a combination of cost containment activities can at least slow the rate of increase. For example, respondents with (1) per-person deductibles of \$200 or more, (2) per-family deductibles of \$400 or more, and (3) reimbursement on the basis of rea-

sonable and customary charges saw 1987-88 increases several percentage points below other respondents. Respondents pointed out, however, that larger contributions from employees can have a negative impact on morale.

- Respondents who implemented case management/utilization review programs (see definitions, page 8) seem to have gained an immediate benefit. Their rates of increase trailed increases for other respondents by 2 to 4 percentage points, on average, for the year following implementation. The correlations are somewhat confusing, however, in that the effect seems to diminish with time. In other words, respondents who put these programs in place in 1984 were just as likely as others to see a big jump in late 1987.
- There is a clear trend toward a broadening of initiatives. In 1985 and 1986, various forms of "cost sharing" (higher deductibles and co-insurance) were the rule. In 1986 and 1987, the movement was toward managed care, utilization reviews, cafeteria benefits, and case management.
- Preferred provider organizations (PPOs) are growing rapidly, and the percentage of employees who participate is exceptionally high. PPOs are in place in about one out of three companies surveyed, and a roughly equal number of respondents are

considering implementation in the near future. When PPOs are offered, about half the employee population participates.

- Employees are going to have to get used to the idea of a "third party" looking in on some aspects of their physician relationships, especially if hospitalization is involved. About half our respondent companies have introduced some form of utilization review, of which prehospital certification is often one component.
- About half the respondents have now gained experience with case management. More than 70 percent of these respondents give the concept a strong positive endorsement for both cost containment and quality of care. If problems arise, they are likely to occur with the organization providing the case management services, rather than with the physician, the patient, or the patient's family, said respondents.

The gap between "cost containment theory" and "actual results" proved to be a source of frustration for our researchers. In theory, PPOs should help reduce the per-employee cost of medical care. Such arrangements, after all, work on the assumption that a favorable fee schedule has been negotiated with those physicians in the PPO group. Our research showed no such correlation, however, perhaps because many of the plans used an enhancement in benefits formula as an incentive for employees to participate. In theory, self-insurance should help contain costs for several reasons. After all, self-insured companies can exercise more control over plan design; moreover, they do not make contributions to the carriers' overhead and profit margins. In two of the three years studied, however, self-insured companies had rate increases higher than did the fully insured respondents.

Although few statistical correlations surfaced, we encountered plenty of anecdotal evidence

that benefit actions had at least some impact on slowing cost increases. For some respondents, self-insurance clearly did have an effect. For others, managed care/utilization reviews did reduce hospitalizations and, consequently, overall costs, over a period of time. But these success stories are lost when the data is examined from a broader perspective.

The world of health care cost management is complex. Sorting out the impact of one factor or set of factors from all the other variables is perhaps impossible. Benefits managers are likely to feel the same, judging from the number of respondents who indicated that their data was inadequate for showing what actions had proved effective. This study made no attempt to rate the efficiency of carriers and review services in providing their clients with data. The complaints surfaced on their own, both in the open-ended questions and during follow-up telephone interviews. One can say with certainty that more than a few of these respondents are irked. They want more extensive data on the services they are paying for—detailed documentation of prehospital certifications and case management activity being the most common concern. Prehospital certification programs in respondent companies may well be reducing the number of stays per 1,000 employees. Without such programs, the 1987–88 cost increase might have been 17 percent rather than 15 percent. But without some report of review activity, employers have no way of knowing what impact the programs had.

All in all, our 323 respondents saw cost increases averaging 15 percent in spite of a spate of cost control activity. One can only speculate on how much higher costs would have climbed had that activity not occurred. The feeling among many of our respondents is that they are eager to look at new ways of controlling costs while maintaining quality of care. But they are operating without the statistical infor-

mation that would give them the foundation for informed management choices.

ABOUT THE STUDY

Our researchers mailed a four-page questionnaire to approximately 8,000 benefit managers in December 1987. The questionnaire collected information in a number of areas:

- Basic costs: approximate per-employee costs for providing medical coverage and percentage cost increases for a three-year period.
- Plan modifications made within the past five years.
- Subjective assessments of what actions (plan design, provider arrangements, health promotion programs, and the like) were having the greatest impact.
- Changes under consideration, both for active employees and retirees.

By mid-January 1988, we had received 323 usable returns, the statistical database for this report. Our researchers probed that database for correlations between lower than average cost increases and plan characteristics. In addition, we conducted in-depth interviews with respondents whose rates of increase proved exceptionally stable during the three-year period. Returns received after the mid-January cutoff were examined for their open-ended and subjective responses, but were not included in the statistical analysis.

LIMITATIONS OF THE STUDY

The analysis is based on what is termed a "self-selecting" sample. That is, it represents respondents who freely chose to complete and

return the questionnaire. Our cover letter clearly stated the objectives of the study: to collect information, both statistical and anecdotal, on what actions benefit managers were taking to control costs, and to provide some insight into effectiveness. If the respondent had more than one plan in place, he or she was asked to complete the questionnaire on the basis of the plan with the greatest cost containment potential.

Our sample is thus biased. Benefits managers who had been actively engaged in cost containment programs would be more likely than others to complete the questionnaire. By doing so, they would receive summary data of what colleagues of like mind were doing.

Moreover, the respondent base is skewed toward the midsize company (\$50 million to \$1 billion in sales). Only 28 percent of our returns came from smaller companies (\$50 million or less in sales). This distribution does not present a representative cross-section of American employers. Consequently, the data should not be taken as presenting national benchmarks on various changes in plan design or provider relationships. Nonetheless, the information is accurate for the 323 respondents. Many of the statistical findings are compatible with findings from survey efforts that did use representative samples.

In presenting our findings, we have avoided language that implies definitive or authoritarian conclusions. Given the complexity of the problem and the limitations of the database, the best that one can say is that certain correlations *suggest* that certain actions may prove effective in containing costs.

Before looking at the results, we provide perspective from the insurance community itself. How does one account for the exceptional rise in costs? What actions and programs are likely to shape both costs and controls in the future? This is the subject of the next chapter.

GLOSSARY

Innovations in health cost management have come so quickly that the terminology has yet to catch up. The result: ask five different professionals to define terms such as "managed care" or "utilization review" and you'll likely get five different answers. The individual components of one practice (utilization review, for example) give essential support to other programs (managed care or case management, for example). It is imperative, then, that we take a page or two to define our terms.

Managed care. An umbrella term used to describe innovations in the delivery of medical care—the provisions for HMOs, PPOs, utilization review, preadmission testing, ambulatory surgery, case management, and the like.

This is the broadest possible term and, possibly, the least useful, in that one vendor's managed care program may well contain a combination of elements different from another vendor's. The term has been defined as any effort in cost management that focuses on the *delivery system* rather than on plan design (for example, higher deductibles). In its narrowest sense, it means that the carrier handles various forms of utilization review.

Utilization review. Any effort to monitor and certify the patient's use of medical services. Mandatory second opinion programs for certain types of surgery fall into this category. The most often talked about program, at present, is prehospitalization review, or precertification. Faced with a potential hospitalization, the patient asks his or her doctor to check with the insurance company to validate coverage. The doctor or nurse telephones the review organization, either the carrier or a utilization review firm. After answering questions about the proposed surgery and the patient's condi-

tion, the doctor requests a specified length of hospitalization. That request is either approved or modified, depending on the reviewer's protocols (usually stored in a database) for what a reasonable hospital stay for such a case is. Similar reviews can be conducted concurrent with a patient's hospitalization, should changes in treatment be in order. Post-utilization review is simply an audit to determine whether the procedures billed were actually performed.

Many in the health insurance industry feel that the medical community often relies too heavily on hospitalization—needless surgery and prolonged stays. For this reason, the utilization review has potential for creating friction between doctors and insurance carriers. The key to success is in the database or system used to determine a reasonable decision for the patient. How much medical knowledge has been built into the reviewer's decision making? Is the system flexible enough to handle exceptions?

Case management. Usually used in catastrophic illnesses, case management provides a tailor-made treatment plan for a particular patient. The plan emphasizes alternative treatment settings and focuses on offering both the best and most cost-effective care. A case worker is dispatched to work with the patient, the patient's family, and the doctor in effecting the best possible treatment. For some catastrophic illnesses, home or hospice care may be most beneficial for the patient. The cost savings for eliminating the full hospitalization more than cover the charges incurred for the case worker's time and for the alternative setting.

Because this system uses what is, in effect, a utilization review, some practitioners use "utilization review" as a general term encompassing the elements discussed above as well as "case management." For purposes of this pub-

lication, we have chosen to use "case management" in the narrow sense—the dispatching of a case worker.

The federal Health Maintenance Organization Act of 1973 mandated that employers of 25 or more persons, if approached by a qualified HMO (health maintenance organization) for inclusion in the employer's benefit plan, must offer the option to its employees in addition to whatever other benefit package it already has. An employer does not have to seek out an HMO, but must offer a dual option if requested for inclusion in its plan by one.

If an employer fulfills two other conditions, in addition to employing more than 25 persons, it is covered by the Act—if it contributes to an employee benefits plan for eligible employees and if it is subject to the Wage-Hour Law. An employer may be liable for heavy financial penalties if it falls under the provisions of the Act and fails to make the option available after receiving a proposal from an HMO.

Qualified HMO. The HMO Act requires that health maintenance organizations offer specific benefits in its benefits package. In addition, there are other requirements stipulated by the Act that the HMO must meet if it is to be qualified.

Traditional or group HMO. HMOs offer employers an alternative to providing fee-for-

service health care to employees. The traditional HMO is an organization of providers—physicians and other health care workers, and affiliated hospitals, usually housed in a single building—that offers prepaid (by the employer and the employee) medical services to the HMO participants. The annual prepaid fee is fixed and covers all services the employee/member may use within the year. There is no need for the employee to complete and submit a medical claims form and await reimbursement.

IPA-type HMO. The traditional or "clinical" HMO may be giving way to a new form of HMO, the individual practitioner association (IPA) HMO. The patient selects his or her doctor from the list of participants and sees that doctor in his or her office. More personal than a traditional HMO, the IPA-type HMO provides a freedom of choice that many people find valuable. The employee pays an annual fee for this service, as with the traditional HMO, regardless of use.

Preferred provider organization (PPO). The employer or carrier develops a list of preferred providers—doctors, hospitals, and other services—selected on the basis of low cost and high quality. The service providers agree to offer service at a reasonable cost in exchange for a potentially higher volume. Unlike the IPA/HMO, the employee does have to complete a medical claims form and wait for reimbursement.

1

Factors and Trends

The real issue is neither lowering nor controlling rising health care costs. The issue is learning how to manage intelligently the costs we are going to incur."

—Dr. Michael McGarvey
Vice President/Health Affairs
Empire Blue Cross and Blue Shield

Interviews with a half-dozen health care cost specialists revealed a wide variety of factors contributing to the current rise in physician and hospital costs. The discussions also suggested a broad range of trends that will shape the costs of the future.

THE FACTORS

The conditions impinging on health care costs include:

- The uninsured or inadequately insured
- Cost shifting
- New medical technology
- New diseases
- Malpractice suits/rates
- The American workforce
- Health care providers

The Uninsured or Inadequately Insured

Although not a business issue per se, it is a factor that impacts on employer contributions. Many Americans take for granted that someone else will see to their health care needs—Medicare for the aged, Medicaid for the poor, and employer-based insurance plans for the employed. The fact, however, is that 30 to 35 million Americans are either uninsured or inadequately insured for medical contingencies.

Medicare and Medicaid funding increases have not matched the growing need. According to Willis Goldbeck, president of the Washington Business Group on Health, "Medicare was designed for people to live 3 to 4 years under its blanket. Now they are living 30 years. By design it should be set up for long-term or chronic care, yet funding has not increased with demand." Comparatively, the Medicaid system has also been delinquent, as Goldbeck sees it: "Medicaid pays for less than half of the poor who are eligible. There are some states that say if a family of three receives or makes \$2,500 a year, that family is too wealthy to be eligible."

In addition, with the advent of widespread corporate downsizing in the United States, health care benefits for many are being cut or discontinued. According to Goldbeck, the idea

of using employment as a distributional vehicle for social services has "historically, from World War II to 1980, been a good idea. But since 1980, it has deteriorated. Not because of benefits per se, but because the nature of employment in America has changed." Today, employment and reemployment tend to be concentrated in the small business sector—where no federal mandates exist on health care benefits. These costs have to be picked up, and most times that means shifting.

Cost Shifting

Hospitals and physicians who lose money on services to Medicare and Medicaid patients (and others who are improperly insured) must make up the deficit through higher charges for other services. The degree of cost shifting occurs in almost direct response to the inadequacy of health care benefits. Individuals who are covered in traditional indemnity plans wind up incurring inflated costs to make up for the services not paid for by those improperly insured—or to make up for the discounts awarded others who have negotiated rates. According to Peter Fox, vice president with the consulting firm Lewin and Associates, "In the non-rate-setting states, as more providers enter into contractual arrangements, those employers in standard indemnity plans will be left to incur the excess costs."

In addition, Goldbeck predicts, "The employer who provides benefits will be picking up a bigger and bigger share of health care costs over the next few years."

New Technology

With all new inventions come new breakthroughs. In medicine, the change is mostly for the better, both in terms of cost and quality of care. But this is not always the case. Sometimes, the cost simply outweighs the medical benefit. The dilemma: when to draw the line

and deny someone the hope of what could be a life-saving measure, however remote. According to McGarvey,

It's very easy to be impartial from the outside. But, say I have a congenital heart problem and a transplant is available. I'd go for it. And if it failed, I'd probably try again. And maybe even a third or fourth time. Cost-wise, it's astronomical. And medically speaking it's probably not advisable. But when there's a chance, you take it, so it's up to the specialists to regulate or cap.

This problem seems to be endemic in American society—everyone looks for the easy cure, rather than turning to prevention. Dr. Bryan Latham, president of Medfacts and author of *Health Care Costs: There Are Solutions* (AMACOM 1983), believes that "the American public has high expectations about what insurance should pay for. They are all looking for the easy cure, the one operation, rather than making lifestyle changes that take time."

And Goldbeck cautions, "Technology is going to be a driving force in medical expenditures. [Persons involved with utilization review] are going to have to look at each piece of technology, separately, to find out whether it reduces or adds to costs. Some advances are actually economically efficient, as well as being a health benefit."

New Diseases

Experts agree that no matter how careful you are in implementing guidelines, caps, and budgets, if a new illness strikes, your costs are going to increase. According to Goldbeck, "You can design the best benefit management system, you can have the world's best contracts with doctors—but if a new disease surfaces, there's a new cost. And it isn't because you failed to manage it. It's simply a new cost."

Such has been the case with AIDS. A survey by the consulting firm Johnson & Higgins reported the following:

Employers say health care costs—up 4.5 percent—will leap another 16 percent by 1990 because of AIDS. This finding is particularly significant since employers spend considerably more on health plans than on other benefits. . . . Surprisingly, the study found few employers initiating positive actions to manage the heavy cost to plans of AIDS. Companies appear to be relying on in-place programs designed more for controlling costs of routine cases rather than the catastrophic cost of a disease like AIDS.

Malpractice Suits and Insurance Rates

Because of the growing number of malpractice suits and consequent increases in malpractice insurance rates, physician prices are rising, as are the number of laboratory tests. According to Goldbeck, "The cost of defensive medicine against malpractice suits gets laid off on employers. And until we fix the tort system for medical care, employers will have no control."

The American Workforce

The baby boomers are entering their 40s, and the average span of a person's employment years has increased. It is not unusual for people to receive employment benefits for up to 35 years. Addressing the subject, John D. Moynahan, Jr., executive vice president at Metropolitan Life Insurance, said, "We're not only talking about the over-65 segment. A large bulk of the employee population is moving into their 40s and 50s, and they tend to get sick more often, resulting in increased use of the health care system."

The effects of an aging population also show up in the shrinking ratio of employed to retired.

The shift has been dramatic. In an article that appeared in the *New York Times* ("Insurance Rates for Health Care Increase Sharply," January 12, 1988), Goldbeck said, "The average manufacturing company in our group had 12 workers for every retiree in 1974; today the average is 3 to 1." To this Moynahan adds, "People are living longer, which is great. But they are also developing diseases associated with advancing age, which are treated at a great expense—and are not necessarily curable. A large part of the cost is going toward chronic disease." Heretofore, persons with these chronic conditions were pretty much left to their own devices, notes Moynahan.

Health Care Providers

Some experts see the oversupply of health care providers—both a physician and a hospital surplus—as a major influence on rising costs. With more doctors seeking patients, a reverse effect, compared to other commodities, has occurred—instead of prices decreasing due to competition, prices have increased. Moreover, procedures are performed that would otherwise be delayed or not initiated. According to Moynahan, "The oversupply of health care providers tends to generate activity." And Fox adds, "Right now there are approximately 200 (give or take 20 to 30) practicing physicians per 100,000 population. In an HMO, the ratio is somewhere between 100 and 200 per 100,000. As more and more patients enroll in HMOs, the fee-for-service doctors end up chasing fewer and fewer patients . . . and the costs rise to maintain them." In the long term, some of the fee-or-service doctor will be "driven out" as a result of the competition, Fox believes.

THE TRENDS

With these factors influencing the rise in health care cost contributions, what actions can—or should—an employer consider? The following

trends emerged from our interviews and questionnaire data. These are measures that benefits managers will have to evaluate, and perhaps implement, in order to manage future costs.

- Employer-driven systems
- Managed care/prevention programs/negotiated or contracted services
- Managed ambulatory services
- Information technology
- Employee responsibility
- A national standard

Employer-Driven Systems

Most experts agree that employer involvement in controlling the rise of health care costs is actually the key to achieving results. In fact, Moynahan believes that employer attitudes have affected the way costs have evolved. "I don't think anything can be done without the cooperation of management. If we had tried to install cost management programs 10 years ago, ones that we do routinely today, management would not have been interested."

The most prevalent view is that employers won't be able to handle the current rises they are experiencing. Costs are simply "going through the roof," as one interviewee commented, and some controls and limits will have to be imposed. According to Fox, "Health care costs are up 11 percent already. Do they have to hit 15, 20, or even 40 percent before someone says, 'Enough is enough?'" "Has that time come?" Fox believes it's near: "I think we will begin to see some fairly dramatic innovations from the employer side, as occurred in the 1970s. In recent years, I believe that a lot of employers have fallen asleep at the wheel." Concurring, Moynahan believes that employers have the control: "It's not a matter of somebody dropping the ball and corporate America having to pick it up. The ball has almost always been in their hands and will continue to stay there."

Managed Care/Prevention Programs/Negotiated or Contracted Services

HMOs, PPOs, and utilization review are the latest arrivals in managed care. It is, some say, too soon to project their impact. According to the results of this survey, growth seems to center on the PPO networks, but group-based HMOs have been on the scene for some time and the experts see them lasting—even with the phenomenal growth in IPA-type HMOs. According to a spokesperson for the HMO trade organization, Group Health Association of America (GHAA), "Trends in the HMO industry last about 36 hours. However, current information suggests that it is easier to control costs in a group-model HMO."

What may have an impact on the performance of HMOs is a new bill, currently in the Senate. The Waxman Bill, or HR 3235, would protect employees from financial discrimination by employers. The bill would further increase HMOs' ability to negotiate with employers on rates and remain competitive as the drive for data increases. According to the Group Health Association of America's spokesperson, if the bill doesn't pass "fewer plans may seek qualification in order to remain competitive." Beginning in 1985 GHAA has compiled cost data on HMOs nationwide. For competitive information, data for 1986 will be available in early summer 1988.

In terms of utilization review, Moynahan relates that experience to date has pointed toward initial, but short-lived, savings. "Many of the programs that have been flat over the last few years began to see large jumps in the fourth quarter of '87 and early '88—increases of 25, 30, even 40 percent." The reason, according to Moynahan, is what he termed their *one-shot* effect. "What they were seeing was the effect of changes in plan design—introduction of UR and other cost management measures—which were immediate. But typically they are one-

shot deals, and once they run their course, costs tend to increase again at the rate of inflation or faster."

Negotiated or contracted services with physician groups, hospitals, HMOs, PPOs, and multi-specialty groups will be an evolving trend in health care management, as benefit managers begin to evaluate costs. According to Goldbeck, "Soon the employer will be saying: 'we will buy X number of knee surgeries, at this rate—and this is what we expect to pay based on standard medical outcomes from the literature; we will not pay for hip replacements in facilities that don't do more than 150 a year; we will send our people to facilities outside the community for care, because we're not looking for convenience, but a nexus of quality and cost savings.'"

According to Fox, "Because of cost shifting, we will begin to see more and more employers with indemnity coverage saying, 'Look, we'd better start negotiating prices, or we're going to get killed.'"

Richard Maturi, executive director of managed care programs at Blue Cross and Blue Shield Association, believes that "employers are being forced to look hard at their provider relationships. They'll have to become increasingly creative with health care providers in administrative and purchasing areas. The relationship has to become mutually beneficial—a move beyond one entity controlling the other." All these ideas are based on an acute care approach.

Latham believes that a stronger push toward prevention programs is a more effective cost control method for employers. "Most of the advances in extending life—especially in quality—have come from breakthroughs in preventive medicine. Changes in lifestyle, which include diet, exercise, and smoking cessation, don't cost a lot of money. The big costs are in the intervention/acute care treatments."

Managed Ambulatory Services

According to the experts, inpatient hospital costs have been the major focus of efforts to drive down the cost of health care. And with some success. The downside is that as inpatient costs have decreased, ambulatory costs have skyrocketed. The reason is twofold. Because there is tighter control on the use of inpatient services, many procedures have moved into the ambulatory setting. This is good for the patient, believes Maturi, because it cuts down on the risk of secondary infections, which result in complications and extended treatment. But, since the focus of cost cutting has been on the inpatient side, as patients moved to ambulatory treatment, the costs rose—due to an absence of controls, limits, or negotiations.

"The costs to employers for outpatient services have compounded due both to improved coverage and increased frequency. The original reason for providing outpatient incentives was to reduce hospital utilization in the absence of any explicit utilization management programs," believes Jim Braun, a health benefits consultant with the Wyatt Company. "Now that these programs are in place and have shifted utilization to the outpatient setting, the rationale for higher outpatient benefits has diminished. Since we do not yet have proven ambulatory care management programs, we need to be cautious about benefit design until acceptable controls and negotiated price limits are in place."

According to Maturi, "The next big step in controlling cost and care has to be in the ambulatory setting—regulations have to be set, and price negotiations made in order to retain the best care for our clients."

Information Technology

When all options have been exhausted, employers will have to begin learning more about

the health care industry. "In order to negotiate contracts with health care providers, employers will have to rely on information technology," believes Moynahan. "It's like buying a car—you have a very clear picture in your mind about what it can do, and what its true value is before you purchase it." Information technology will be the wave of the future. Employers will research their providers—what they're doing, what they're charging, the experience level of doctors, the quality of services provided by a facility. More and more, providers will be required to supply data on their day-to-day business activities.

According to Latham, "The trend of monitoring what doctors and hospitals are doing has become very popular. Utilization review has become a national approach to understanding costs and weeding out unnecessary procedures." But, Latham cautions, "Utilization review is a learning mechanism, not a cost savings tool. It will eventually be replaced by more sophisticated measures of evaluation."

And Pizzano adds, "Quality assurance programs are going to be vital to employer evaluations of services."

Employee Responsibility

All sorts of plan designs can be created, but when employees know that they can go to a doctor or a hospital and be covered in full, or nearly so, for all their expenses, there is no real comprehension as to the costs they are incurring. The terms "co-payment" and "deductible" (either instituting them or raising current levels) are echoing throughout the benefits community. According to Moynahan, "We are trying to convince employers that in-full, first dollar coverage of everything is inappropriate. It is important that reasonable restraints be placed on employees. Certainly not when it gets to the catastrophic level, but at the early stages of health care use."

In a worse case scenario, Moynahan has heard whispers that employers are considering flat contribution guidelines, letting employees pick up the increases. "Some employers are simply saying that they can't handle the costs themselves, and they want to set a flat contribution fee, letting future increases in health care cost fall on their employees," explained Moynahan. "It is certainly not a full trend yet, but it may grow in popularity. Flexible benefits then would become a major part of the benefits package."

A National Standard

Although this is decidedly a last-step measure, Fox mentioned that a few of his colleagues have been entertaining the idea. "Employers are going to start taking tough measures to control their costs. I've spoken with people in the field who go as far as to say that there will be a round when employers take a hard stand on health care prices—and if that doesn't bring around change, there will be tremendous support [from employers] for instituting a national health insurance program. One that includes national controls on pricing."

HEALTH CARE COSTS VS GNP AND INFLATION

"When people are well they don't shop. When they are sick they don't care."—unattributed.

This sums up the reasons why health care costs have soared over the last few years. People simply don't shop carefully for services—when it comes time to use them, somewhere in the back of their minds lurks the notion, if they can't pay for it, someone else will. But commentators wonder how far above overall inflation, or how large a percentage of the GNP, those who foot the bill are willing to allow before they say, "Enough is enough!" Currently, experts are looking at costs running 5

percentage points above inflation and totaling 11 percent of the GNP. Some predict that health care cost inflation could reach double-digit proportions over the next few years, and that 15 percent of the GNP for health care expenditures is a likely eventuality.

"If inflation itself stays down in the 5 percent area, then my feeling is that health care inflation will continue to run roughly double—from a national perspective," believes Goldbeck. "The key is not double digit, but double the percent of inflation, as opposed to four or five times that number."

Conversely, Fox is looking for more containment. "In the last year or so there has been a rapid resurgence of the rising health care cost phenomenon—with increases running approximately 5 percentage points above overall inflation. Costs will continue to go up. But, if these costs could be contained at 1 or 2 percentage points above inflation, and maintained, employers would be a lot more comfortable—particularly since there is a widespread view that these costs are not managed efficiently."

When asked about the chance of health care costs reaching 15 percent of GNP, Moynahan

said, "They could. I don't know if anyone is predicting that as yet. Actually I'm keeping my fingers crossed that they don't get that high. But they could."

Unlike Moynahan's cautious estimates, Goldbeck sees 15 percent as inevitable. "I think we are probably moving toward 15 percent of GNP. Previously, growth has been flat. We spent 10 years getting from 9 to 11 percent—so on an annualized basis there wasn't a whole lot to talk about. But from a standpoint of plotting the nation's economic pattern strategically, an increase in the percentage of GNP spent on health care is inevitable. Whether or not the system receives more government funding, I believe we are headed close to 15 percent—simply because so many people have to be brought into the system."

McGarvey, on the other hand, in a seminar at the American Management Association's headquarters on evaluating health care cost, ventured a slightly different prediction. "Currently 11 percent of the GNP is spent on health care. By the year 2000 it could be 13 percent. At that time, if not before, quality will become the most important issue."

2

Changing the Plans

Benefit managers have been far from idle during the past five years. About half the 323 respondents raised per-person and per-family deductibles, and an equal number introduced case management and utilization reviews. Two-thirds implemented mandatory second opinions for specified surgical procedures; 4 out of 10 brought reimbursements in line with reasonable and customary fee schedules. The future will be marked by an equal number of changes. Respondents clearly see participation in preferred provider organizations (PPOs) increasing. Those that did not raise deductibles or implement utilization reviews are seriously considering doing so. Many see changes in plan structure for their retirees.

Before taking a closer look at these changes, we would do well to sketch in the background data on costs and funding arrangements. Clearly, costs have escalated, and our respondents were reacting to very real problems.

For our respondents, the per-employee medical premium costs (total premiums divided by active employees) averaged \$1,774—less in smaller organizations (\$1,590), more in larger companies (\$1,961). Perhaps more instructive than these numbers, however, are the year-to-year percentage increases in premium costs. For most respondents, the 1985 and 1986 premium jumps were sizable, but not dramatic—in the 7 to 8 percent range, on average. The

1987-88 renewals were a different game: an average 15 percent increase. Thus, over the three-year period, respondents saw their companies pay about 10 percent more *each year* to provide their employees with medical insurance. And this at a time when inflation was inching upward at 4 to 5 percent per annum. Perhaps those respondents who had increases approximating these averages should feel fortunate: 10 respondents reported 1987-88 increases upwards of 50 percent. The largest increase: a whopping 128 percent.

The increases came without respect to company size, as Exhibit 2.1 shows. A look at cost differentials by type of business activity does reveal some significant differences, however. The diversified conglomerates in the respondent base seem to have fared far better than the other firms. The nonprofit sector, in contrast, was hit with the most dramatic increases. (See Exhibit 2.2.)

FUNDING ARRANGEMENTS

Within AMA's whole sample of 323 companies, no single type of funding arrangement is overwhelmingly preferred. Indeed, the distribution is remarkably even among minimum premiums, administrative services only (ASO), fully insured, and self-insured funding policies

Exhibit 2.1. Average percentage increases in medical insurance rates, past three years.

	<i>All respondents</i>	<i>Company size</i>		
		<i>Small</i>	<i>Midsize</i>	<i>Large</i>
1985	7	8	8	6
1986	8	7	9	9
1987-88	15	15	16	15
Number	323	92	142	89

Exhibit 2.2. Average percentage increases in medical insurance rates, by company category.

	<i>Diversified conglomerate</i>	<i>Manufacturing</i>	<i>Service— for profit</i>	<i>Nonprofit</i>
1985	1	7	6	12
1986	8	9	9	7
1987-88	11	14	16	18
Number	14	109	132	49

Notes: N = 304; 19 respondents did not answer the question on type of business.

(see Exhibits 2.3 and 2.4). Preferences are apparent, however, by organization size. A third of the large firms report using ASOs, compared with just 8 percent of the small firms. Conversely, smaller companies show a greater use of fully insured policies; more than half the small firms are fully insured, compared with 12 percent of the large firms.

Nonprofit service firms are as likely to self-insure as service-for-profit companies, less likely to use minimum premium arrangements. But here, as elsewhere, the size of the organization is a more important variable than its business category.

CHANGES IN PLAN DESIGN/PROVIDER ARRANGEMENTS

Dynamic change has marked the management of health care benefits over the past five years. Respondents report busy adjustments in allowable deductibles, reimbursements, and review procedures (see Exhibit 2.5). The *lowest* level

of activity concerns *limits* on reimbursements for emergency room care; the *greater* numbers involve second opinions and various forms of managed care. The message the numbers convey is that companies are giving more attention to the question of whether indicated treatments are truly necessary—but when such indications are confirmed (by second opinions or by case managers), companies are more than willing to bear the costs.

The years of implementation tell something of a story. Judging by the modes—that is, the year that respondents gave most frequently for each change—we can say that in 1985, the focus was on levels of reimbursement; in 1986, attention shifted to deductibles; and in 1987, various forms of managed care took precedence. As in every field, there are fashions and fads at work.

A breakout by organization size (see Exhibit 2.6) shows that in almost every regard, large companies were more active in altering plan design than small or midsize firms. The reader should be aware that this is a familiar pattern

Exhibit 2.3 Funding arrangements, by company size (percentage distributions).

	Whole sample	Company size		
		Small	Midsize	Large
Minimum premium	24	14	28	28
Administrative services only	16	8	12	33
Fully insured	29	55	21	12
Self-insured	29	22	36	17
No answer	2	1	3	0

Note: For number of respondents in each size category, see Exhibit 2.1.

in every survey activity in which AMA has engaged in recent years. Large companies *always* report a higher share of innovation and experimentation, whether in benefit management, information systems, vendor relations, or what-have-you. The reason: large firms have the resources to devote to such affairs and often make arrangements for pilot programs in a particular division, subsidiary, or locality. This is not to say that megafirms have a patent on innovation; that is far from the truth. *Individually*, small companies are often more avid about change and can inaugurate such changes more swiftly than large firms. But as a *group*, at any given time and in any single area, a greater percentage of large firms will be active in revising their systems.

Thus the large firms are first to report the newest practice. As we have seen, 1987 was "the year of managed care," and large firms were nearly twice as active as small ones in adopting case management, utilization reviews, and precertification. In 1985 and 1986, in areas where changes were more frequently reported, the difference in activity between large firms and small ones proved far less dramatic.

A similar pattern emerges in Exhibit 2.7, which breaks out the data by business category. Diversified conglomerates report the greatest activity in revising plan design—and diversified conglomerates are, by their nature, large companies.

In fact, it is surprising to see so *little* differentiation by business category. Manufacturers reported more activity than service companies in limiting individual and family deductibles, but there are few other statistically significant variations by industry.

CHANGES IN DEDUCTIBLES

Half the companies polled reported increases in per-person deductibles over the past five years, and nearly as many (48.6 percent) told us they'd raised per-family deductibles in the same period. Often such increases go hand-in-hand, as part of an overall restructuring of benefits; companies that raise the one tend to raise the other as well.

If we may judge by year of execution, deductibles were the first area in which respondents made revisions. How great were these changes? Forty-three percent raised the deductibles into the \$200 range; 8 percent into the \$201 to \$250 range (see Exhibit 2.8). A bare 5 percent set the per-person deductibles greater than \$250.

Increases were far greater in per-family deductibles (see Exhibit 2.9). Nearly half the respondents reported some increases. Typically, the new deductibles fall between \$200 and \$500, and even larger increases were not infrequent: three respondents raised the per-family deductible by \$1,000.

Exhibit 2.4. Funding arrangements, by type of company (percentage distributions).

	<i>Diversified conglomerate</i>	<i>Manufacturing</i>	<i>Service- for profit</i>	<i>Nonprofit</i>
Minimum premium	21	29	26	18
Administrative services only	35	14	15	20
Fully insured	7	23	33	37
Self-insured	36	32	26	25
No answer	0	2	1	0

Notes: N = 304. For number of respondents in each category of business activity, see Exhibit 2.2.

Exhibit 2.5. Percentage of respondents making recent changes in plan design or provider arrangements.

	<i>Percent</i>	<i>Year*</i>
A larger per-person deductible	56	1986
A larger per-family deductible	48	1986
A larger out-of-pocket maximum	33	1987
Mandatory second opinions	65	1986
Cafeteria benefits	18	1987
Limited reimbursements, emergency room care	14	1986
Managed care (e.g., carrier handles precertification utilization review)	65	1987
Case management	53	1987
Utilization reviews	50	1987
Higher reimbursements, outpatient surgery	51	1985
Reimbursement based on reasonable and customary fee schedules	40	1985
Higher co-insurance payments	25	1985

*Year of implementation most frequently given.

Notes: N = 323. Tabulation shows only percentage of respondents implementing changes within the past five years. The questionnaire wording did not provide for information on implementations prior to 1982.

ORGANIZED PROVIDERS

Propelled by federal and state laws that require many companies to offer such care, health maintenance organizations (HMOs) in their various forms have taken off in recent years. Seventy percent of the respondents reported participation in some form of organized provider care, and most of these offer a combination of plans, some involving individual practi-

tioner associations (IPAs) or preferred provider organizations (PPOs).

Definitions of organized provider plans are not strict. Among the various criteria that identify one type or another, the key elements have to do with the nature of company ownership and management, and the manner in which the employee is billed. The latter is, of course, a matter of primary concern to the employee.

Exhibit 2.6. Percentage of respondents making recent changes in plan design, by company size.

	<i>Small</i>	<i>Midsize</i>	<i>Large</i>
A larger per-person deductible	45	58	62
A larger per-family deductible	43	51	48
A larger out-of-pocket maximum	26	34	40
Mandatory second opinions	61	60	76
Cafeteria benefits	21	16	18
Limited reimbursements, emergency room care	21	25	25
Managed care (e.g., carrier handles precertification utilization review)	50	68	74
Case management	35	56	65
Utilization reviews	32	57	60
Higher reimbursements, outpatient surgery	36	56	58
Reimbursement based on reasonable and customary fee schedules	38	42	37
Higher co-insurance payments	20	27	27

Notes: N = 323. Tabulation shows only percentage of respondents implementing changes within the past five years. The questionnaire wording did not provide for information on implementations prior to 1982.

Exhibit 2.7. Percentage of respondents making recent changes in plan design, by business category.

	<i>Diversified conglomerate</i>	<i>Manufacturing</i>	<i>Service-for profit</i>	<i>Nonprofit</i>
A larger per-person deductible	33	79	54	51
A larger per-family deductible	64	53	42	51
A larger out-of-pocket maximum	50	37	36	20
Mandatory second opinions	86	67	66	53
Cafeteria benefits	21	16	17	29
Limited reimbursements, emergency room care	43	28	19	16
Managed care (e.g., carrier handles precertification utilization review)	71	67	62	69
Case management	78	55	51	43
Utilization reviews	50	55	45	53
Higher reimbursements, outpatient surgery	79	50	52	33
Reimbursement based on reasonable and customary fee schedules	43	41	39	39
Higher co-insurance payments	36	29	21	27

Notes: N = 304. Tabulation shows only percentage of respondents implementing changes within the past five years. The questionnaire wording did not provide for information on implementations prior to 1982.

Exhibit 2.8. Current per-person deductibles: percentage of respondents that raised deductibles in the past five years.

<i>New Deductible (Range)</i>	<i>Percent</i>
Less than \$100	2
\$100 to \$150	42
\$151 to \$200	43
\$201 to \$250	8
\$251 to \$300	2
\$301 to \$350	0
\$351 to \$400	1
\$401 or more	2

Note: N = 166

Exhibit 2.9. Current per-family deductibles: percentage of respondents that raised deductibles in the past five years.

<i>New Deductible (Range)</i>	<i>Percent</i>
\$100 to \$200	2
\$201 to \$300	35
\$301 to \$400	26
\$401 to \$500	20
\$501 to \$600	9
\$601 to \$700	1
\$701 to \$800	4
\$801 to \$900	1
\$901 to \$1,000	3

Note: N = 141

and it is the employee who is empowered to choose the plan in which he or she will participate.

The federal HMO Act addresses companies both subject to federal minimum wage laws and employing 25 or more persons in a given quarter. No surprise, then, that 85 percent of the large companies in the sample offer some form of organized provider care (see Exhibit 2.10). Large firms are twice as likely as small ones to offer "traditional" HMOs or the newer IPA type of HMO plan; the numbers show no im-

portant differentials by corporate size among companies that offer PPOs.

One number pops out when respondents are identified by industry type (see Exhibit 2.11). Nonprofit organizations are far more active than any other group in offering preferred provider organization care. The same chart shows that diversified conglomerates lead in offering IPA-type HMOs. But conglomerates by their nature tend to be large organizations, and the figure is more a function of corporate size than of business activity.

EXTENT OF PARTICIPATION

Whereas companies are less likely to offer preferred provider organization programs than other types of organized provider care, employees prove most avid in accepting PPOs (see Exhibit 2.12). The figures are dramatic: three times as many employees sign up for PPOs than for "traditional" HMOs, and five times as many prefer PPOs to IPA-type HMOs.

Preferred provider organizations differ from other organized provider programs in that they maintain a fee-for-service feature. (HMOs, both traditional and IPA type, substitute a fixed

annual rate.) Evidently, employees are optimists. They tend to believe that they will have minimal needs for medical care and expect to "beat the system"—that is, to pay less on a fee-for-service basis than an HMO charges with its fixed fee for unlimited services. Perhaps for this reason, more companies are considering PPOs than any other new health care service (see Exhibit 2.14 below). If, ultimately, health care insurance is a consumer-driven market, PPOs have a bright future.

But respondents, who are benefit managers, expect otherwise (see Exhibit 2.13). Whereas they forecast increasing participation in every

Exhibit 2.10 Percentage of respondents offering HMOs, IPAs, and PPOs.

	<i>Whole sample</i>	<i>Company size</i>		
		<i>Small</i>	<i>Midsize</i>	<i>Large</i>
Traditional HMO	54	41	48	78
IPA-type HMO	42	29	35	65
PPO	27	20	30	28
None of above	31			

Notes: N = 323. For distribution by size, see Exhibit 2.1.

Exhibit 2.11. Percentage of respondents offering HMOs, IPAs, PPOs, by type of industry.

	<i>Diversified conglomerate</i>	<i>Manufacturing</i>	<i>Service-for profit</i>	<i>Nonprofit</i>
Traditional HMO	64	55	55	51
IPA-type HMO	57	41	40	49
PPO	29	26	23	43

Notes: For number of respondents in each category, see Exhibit 2.2. Percentages total greater than 100 because of multiple options.

Exhibit 2.12. Average percentage of workforce participation when an HMO/PPO is offered.

Traditional HMO		17%
IPA-type HMO		10%
PPO		49%

Notes: This chart should be interpreted with reference to Exhibit 2.10. For example, 27 percent of our 323 respondents offer PPOs. In these respondent organizations, 49 percent of the workforce participates.

form of organized provider care, they see the greatest increase coming from participation in IPA-type health maintenance organizations, which combine the fixed-fee feature of traditional HMOs with a greater allowance for individual selection of private-practice physicians.

The specific service aside, more than half the respondents predict an increase in employee participation in organized provider care, while few foresee a decrease.

CHANGES, POSSIBLE AND LIKELY

Respondents were asked to report what changes are currently under consideration at their companies, and which of these changes

are most likely to occur. In many areas, the results reveal (see Exhibit 2.14) an inverse ratio: that is, the fewer companies considering a particular change, the more likely it is to be implemented in those few companies.

Examples: Whereas a relatively high percentage of respondents are considering adding flexible benefits (28 percent), only 56 percent of these respondents think such changes will be made. Conversely, a bare 5 percent are considering a wellness program, but 90 percent of these 16 companies will likely implement such a program. Similar patterns occur concerning HMOs (a high 26 percent have them under consideration, a low 59 percent say they are likely to be implemented) and managed care provisions (10 percent considering, 75 percent predicting implementation).

Exhibit 2.13. Will workforce participation in HMOs/PPOs increase or decrease?

	<i>Increase</i>	<i>Decrease</i>	<i>Stay the same</i>
Traditional HMO	53%	23%	24%
IPA-type HMO	67	12	21
PPO	56	20	24

N = 226. Respondents not offering any of these provider options did not answer the question.

Exhibit 2.14. Changes under consideration (in order of most frequently cited).

<i>Change</i>	<i>Percent considering</i>	<i>Percent of these likely to implement</i>
PPO	32	71
Flexible benefits	28	56
HMO	26	59
Higher deductible/co-payment	14	74
Managed care	10	75
Utilization review	6	73
Wellness programs	5	90
Case management	4	75
Triple options	4	50

Notes: N = 323. Percentages total more than 100 because respondents checked more than one change.

RETIREE BENEFITS

Respondents have been less active in the area of retiree benefits. Nearly half the respondents offer no benefits at all to retirees. Of the remainder, fewer than half foresee any change in existing plans. But where activity is indicated, the trend is toward matching packages.

A comparison of Exhibit 2.5 and Exhibit 2.15 makes the point. Increases in per-person deductibles, mandatory second opinions, case management, and managed care provisions lead the lists on both charts.

Exhibit 2.15 also reveals that companies do not tinker with their benefit plans for retirees; they make many changes or none at all. The figures in the "no change" column confirm the fact.

Sixty-two percent of respondent firms that offer retiree benefits anticipate no change in prefunding policies; 52 percent have no plans to add case management programs; the other figures in the column all fall within that narrow range. Adding the figures in the "recently changed" column and the "likely to change" column will, of course, result in a similarly narrow range. These findings relay a clear message from respondent companies: a fine-tuning in benefit packages is a rare thing, whereas a major overhaul was reported, or is predicted, by approximately 4 out of every 10 respondents.

The hot item: prefunding of retiree benefits. There has been little activity here to date, but that will soon change. Prefunding leads the list among "likely changes." Forty-three percent

Exhibit 2.15. Recent and anticipated changes in retiree benefits (percentages).

	<i>Recently changed</i>	<i>Will likely change</i>	<i>No change</i>
Increase per-person deductible	23	23	54
Add second opinions	30	13	57
Add managed care	23	19	58
Add case management	27	21	52
HMO/PPO	14	25	60
Prefunding of benefits	4	33	62

Notes: N = 167. Excludes 156 respondents not offering any retiree benefits.

Exhibit 2.16. Percentage of respondents making recent changes in retiree benefits, by company size.

	<i>Small</i>	<i>Midsize</i>	<i>Large</i>
Increase per-person deductible	11	26	29
Add second opinions	24	31	32
Add managed care	12	20	32
Add case management	11	22	39
HMO/PPO	3	14	20
Prefunding of benefits	3	3	6

Notes: N = 167. Excludes 156 respondents not offering any retiree benefits.

of the large companies that offer retiree benefits call prefunding a "likely change," as do 32 percent of the midsize firms. Activity was lower in smaller firms: only 15 percent will "likely change." This brings the overall average (total respondents) down to the 33 shown in Exhibit 2.15.

Here as elsewhere, large companies are far more active in revising benefit packages (see

Exhibit 2.16). But the very popular option of adding mandatory second opinions proves an exception. Nearly as great a share of small companies have recently implemented second opinion policies as large ones. The opposite is true for health maintenance and preferred provider organizations. So far, these are large-company initiatives: 20 percent of large companies have added this option for retirees, compared with just 3 percent of small ones.

3

The Search for Solutions

A majority of respondents are optimistic that health care costs can be contained. That majority is slimmer than one might expect, however. One respondent out of five feels that conditions have become complicated to the point that plan design changes or other controls will have little or no impact; an equal number are uncertain as to whether company actions can or cannot make a difference.

In spite of these mixed feelings, many of our respondents have clear ideas about what controls have the most potential. Higher deductibles and out-of-pocket expenses *do* make employees more careful in spending their health care dollars, respondents feel. Various aspects of managed care and utilization review offer hope of cost containment. Case management *is* living up to its potential, providing care that is both humane and cost effective. In contrast, company-sponsored wellness programs—although possibly a boost to employee morale—seldom translate into lower medical costs, according to the respondents.

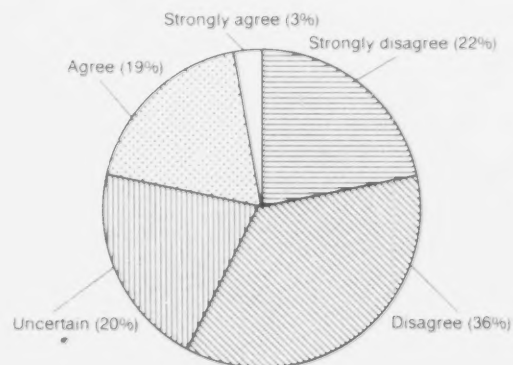
These conclusions emerge from responses to a series of subjective questions midway in our questionnaire. After filling in hard data on rate increases, plan changes, and the like, respondents were asked to agree or disagree with a series of three statements. One of these read:

Company efforts to contain costs will, in the long run, have little or no impact—the cost problem is too complex.

The majority of respondents (58 percent) either *disagreed* or *strongly disagreed* with this statement, thus aligning themselves with the converse: company efforts *can* have an impact; although the problem is complex, that complexity can be dealt with. (See Exhibit 3.1.)

It is easy to understand why other respondents (22 percent) either agreed or strongly agreed with the statement. Outside the benefit mana-

Exhibit 3.1. Responses to the statement, "Efforts to contain costs will have little or no impact. . . ."



ger's sphere of control are those factors most often cited as fueling medical cost increases: medical malpractice insurance for doctors and the increased use of more sophisticated diagnostic testing. For many respondents, the sharp upturn in 1987-88 came in spite of recent changes in plan design and provider arrangements. Moreover, the long-term impact of many of the newer, widely heralded controls (case management, utilization review) has yet to be fully measured.

This mixture of developments—promising (but as yet unproved) new controls balanced against the apparent uncontrollables—may explain why many of our respondents (20 percent) took a middle-of-the-road position. They are simply uncertain. Company actions may make a difference—or history may repeat itself, dishing out double-digit increases to those who thought they had done an excellent job of managing containment.

PAYING MORE MEANS MORE CAREFUL BUYING

The ambiguities just cited have not stifled the search for solutions. Since the early 1980s, industry surveys have signaled a clear trend toward various forms of cost sharing (higher deductibles, higher co-insurance). The rationale behind the trend is clear: the more an employee pays for a service, the more carefully he or she will think through the options before deciding to purchase. To test whether benefit managers still see this as an effective approach, we asked respondents to agree or disagree with this statement:

Higher deductibles/out-of-pocket expenses make employees more prudent in their use of medical care.

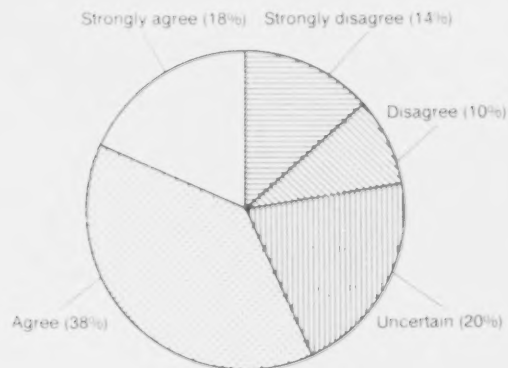
The results are virtually the inverse of those for the prior question: 56 percent agreed or

strongly agreed with the statement (see Exhibit 3.2). The larger the company, the stronger the feelings.

Statistical relationships in our database suggest that this opinion has merit. Respondents that implemented a per-person deductible of \$200 or more before 1986, on average, saw a 1987 increase several percentage points below that of other respondents. The same relationship applies to those who implemented per-family deductibles of \$700 or more before 1986. Again, the database is too small for a definitive answer. But the differential is clearly there for these 323 companies. On the other hand, one might point out that an increase in costs of "only" 13 or 14 percent is not a major victory. The higher deductibles seem to have slowed cost acceleration, rather than breaking its momentum.

Does cost sharing have a negative side? Some respondents—a 24 percent minority—feel that the cost-sharing efforts may be misguided. "Health care is not a commodity that one shops for, like eggs or clothing," wrote one benefits manager in this camp. The negative impact of cost sharing emerges even more clearly in the responses to our next statement:

Exhibit 3.2. Responses to the statement, "Higher deductibles/out-of-pocket expenses make employees more prudent. . . ."



Higher deductibles/out-of-pocket expenses hurt employee morale and weaken the company's ability to attract or retain employees.

Respondents were evenly divided. About a third were concerned that cost sharing could weaken the firm's hiring position; another third felt that cost sharing had little or no impact on the company's ability to attract and retain employees; the remaining one-third were uncertain. (See Exhibit 3.3.) One exception: respondents from smaller companies showed a slightly greater tendency to agree with the statement. The response makes sense. More than a few presidents of small companies have lamented the loss of talented managers to larger firms—the latter able to offer more attractive salaries, career options, and benefits.

STILL, COST SHARING IS ONE KEY TO CONTAINMENT

Our questionnaire put this query to the respondents:

Of all the initiatives listed thus far [in the questionnaire], which three, in your opinion, hold the most promise for cost control?

Approximately 200 respondents (two-thirds of our respondent base) completed the question, with most citing either one or two initiatives. By far the largest group (48 percent) cited such items as higher deductibles, higher out-of-pocket expenses, and higher co-insurance.

A second group (32 percent) pointed to some form of utilization review, such as prehospital certification or audits to see whether services billed were actually performed. Seventeen percent singled out second opinion programs; 14 percent saw outpatient testing and surgery as the most promising solutions. Twelve percent cited PPOs, and an equal number looked closer

to home, that is, to company-sponsored wellness programs.

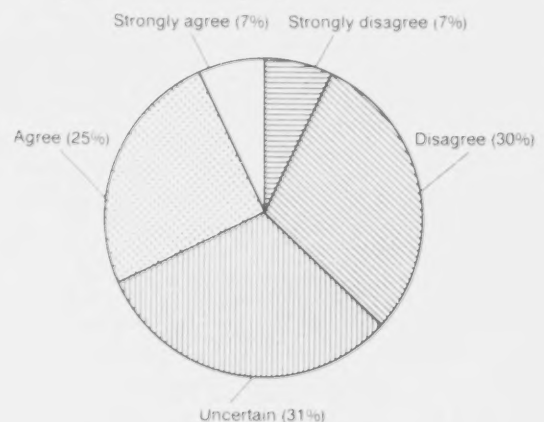
Again, the terminology complicates meaningful analysis. As we noted in the Highlights and Conclusions section, the term "managed care" is being used as an umbrella to refer to what is, indeed, a complex bundle of initiatives. If all the actions listed in the previous paragraph were combined into the category "managed care," this tactic would emerge as by far more promising than cost sharing. Thus, one can surmise that many benefits managers will listen attentively to those vendors who are currently selling some form of managed care.

Cost sharing and managed care are, of course, not mutually exclusive. Respondents commonly cited some form of both: higher deductibles as a first choice, followed by some aspect of managed care.

DRUG AND ALCOHOL REHABILITATION

"Some people fear that the costs of drug and alcohol rehabilitation will escalate in the years

Exhibit 3.3. Responses to the statement, "Higher deductibles and out-of-pocket expenses hurt employee morale. . . ."



ahead," stated our questionnaire. "Has your company made any provisions to contain these costs?" Respondents who answered affirmatively were invited to describe the provisions.

Fifty-three percent of the participants indicated that, yes, the company had looked at this problem and put controls in place. Almost 9 out of 10 of the provisions cited involved some form of coverage limitation: the number of days that would be covered in a rehabilitation center, and the number of visits, per lifetime. Representative answers:

We revised our policy to provide for inpatient confinement in an approved rehabilitation facility or hospital for up to 28 days (33 days for detoxification). This is limited to a lifetime maximum of two stays. After a \$100 deductible, cost is paid at 80 percent.—*Midsized manufacturer, sheet metal products*

A maximum of two treatments are allowed per lifetime: \$27,000 maximum per treatment for outpatient service; 30-day maximum for inpatient.—*Midsized semiconductor company*

Limit of one treatment per family member; \$50,000 lifetime maximum.—*Midsized manufacturer, factory automation equipment*

Of the 171 respondents who answered this question, 42 percent put a dollar limitation on lifetime coverage, 20 percent put a ceiling on the number of days in a rehabilitation center, and 27 percent specified a dollar maximum for outpatient treatment.

Some form of limitation seems appropriate. The most prestigious drug rehabilitation centers, such as the Fair Oaks Hospital Group, carry a-thousand-dollar-a-day fees. The bills for inpatient treatment, ranging from four weeks to six months, average \$56,000, with a high of \$160,000 and a low of \$28,000. At the lower end of the scale, the Betty Ford Center charges \$5,000 per term of treatment and Ha-

zeldon in Minnesota charges \$4,000. A number of mid-range centers charge in the \$10,000 category.

Interestingly, many of the initiatives being talked about for other aspects of medical care were not frequently cited. Only 7 percent indicated that they were encouraging outpatient treatment; only 2 percent said that they had implemented precertification. Outpatient treatment for drug abuse is the subject of some controversy. Various studies have suggested that costs for rehabilitation can be greatly lowered and the chances of success increased by various forms of outpatient treatment, some of which involve the use of stabilizing drugs.

AMA's 1987 research study, *Drug Abuse: The Workplace Issues*, highlighted this approach, citing testimony to its potential effectiveness from a number of spokespersons in the field, as well as evidence from several recent studies. The following paragraphs have been extracted from that report:

"A solution suggested by a number of the experts [AMA staff researchers] interviewed, calls for more outpatient treatment—and added insurance coverage for this treatment. Dr. Richard Rawson, executive director for the Matrix Center in Beverly Hills, an outpatient addiction center, points to figures in a study* he has published. Dr. Rawson and Dr. David Ockert employ nonaddictive, non-mood-changing antidepressants as part of their outpatient therapy for cocaine addiction:

In this first study the cost of the hospitalization was approximately \$12,000 per 28-day episode. If a psychiatrist followed the patient in the hospital, an additional \$3,500 charge was incurred. The cost of the outpatient episode was \$3,600 for six months.

**Cocaine Treatment Outcome: Cocaine Use Following Inpatient, Outpatient, and No Treatment, Richard A. Rawson, et al., in Proceedings, 1985 Meeting, Committee on Problems of Drug Dependence, Inc.*

"West Coast treatment costs are considerably lower than those in the East.

"More coverage for outpatient therapy is one workable solution to the cost differential. IBM has recently announced new benefits that expand coverage for outpatient drug and alcohol treatment. 'Our hope is that providing benefits that are more flexible and with greater options will enable people who need help to obtain the kind of care that is required,' states Bill Ehrlich, IBM's corporate manager of health and medical benefits."

"WELLNESS" PROGRAMS: PROMISES, BUT NO REAL EFFECTIVENESS?

It would stand to reason that employees who stay healthy incur lower health care costs. "Wellness" initiatives, adopted with this premise in mind, seek to help employees attain healthier lifestyles; the thrust is preventive. The approach assumes as its *raison d'être* a link between employee health and the bottom line.

The shift toward prevention as a social trend in the United States began some 15 to 20 years

ago. John Naisbitt documented it in his best-selling book *Megatrends* (1983):

Beginning with the granola ethic in California a dozen years ago, and moving through new concerns about nutrition and physical well-being, there has been a reconceptualization of health care from a sickness orientation to a wellness orientation, and from short term to long term.

Companies began adopting wellness programs in the early 1980s; these companies were, indeed, forerunners. But in the wake of the recession of the early 80s and subsequent economic constraints, health care cost containment via wellness initiatives has been limited.

A separate question of our questionnaire addressed the wellness issue. Respondents were asked to rate six initiatives as to effectiveness in terms of actual cost containment.

Judging from the responses we received, the "state of the art" of wellness programs in business, in general, is probably very low. Although 40 percent of our respondents *do* do some kind of health education, and 21 percent

Jim Braun, a Wyatt Company health benefits consultant, adds additional perspective:

There is a growing consensus among both providers and payers that many patients can be treated more effectively and more economically in an outpatient setting. The questions of how to identify these patients and assure the proper treatment setting, however, are not easily solved. As with medical conditions, we must structure the right balance between utilization management and benefit coverage. Many companies have begun to implement review programs that include psychiatric and substance abuse treatment on both an inpatient and outpatient basis. This may prove a more finely honed instrument to provide cost effective care than the relatively blunt instrument of financial incentives alone.

Without question, approaches such as this will receive greater attention in the years ahead, the result of growing concern about substance abuse as both a social and workplace issue.

FOCUS ON OUTPATIENT TREATMENT FOR DRUG ABUSE**

There is preliminary and fragmentary statistical evidence that outpatient treatment that includes drug therapy for cocaine addiction can be successful. A study of drug users recruited from a cocaine hotline and treatment program divided 83 subjects into three self-selected groups: those receiving no formal treatment; those hospitalized for an average of three weeks and then referred to voluntary aftercare; and those in continuing outpatient care employing drug therapy for six months. The percentages returning to monthly cocaine use in the eight months following the initial interview:

No formal treatment	47 percent
Inpatient hospitalization	43 percent
Outpatient care plus medication	13 percent

"Current hospital aftercare programs may not be appropriately oriented for cocaine users," the authors of the study concluded. It appears that the hospital program in this study retained fewer than 30 percent of the subjects in aftercare.

Considering the costs involved in inpatient drug abuse treatment, the poor success rate documented in this study is staggering.

"Outpatient treatment for cocaine dependency is a viable form of treatment in which subjects will participate for up to six months on a fee-for-service basis," the study concluded, with the caveat that "this conclusion is extremely guarded due to a large number of methodological issues and the short follow-up period."

Dr. David Ockert of New York City's Parallax Center has been tracking data on the success of his outpatient program, which employs drug therapy for cocaine abuse, and finds the same percentage of patients remaining drug-free: 87 percent. He cites other advantages to such treatment:

Outpatient treatment for drug abuse is not only less expensive than hospitalization, but it also allows the individual to remain in the community, at home, and in the workplace. So the cost, both emotional and financial, is less for both the individual and the employer than inpatient hospitalization would be.

The very thing that makes a hospital effective for detoxification—its restrictive environment—may foreshadow a relapse for the released patient, Dr. Ockert explains. "In a hospital you don't have your normal environmental triggers, and [the patient] knows he or she can't get the drug. There are studies that show that the number of impulses for, say, alcohol is significantly lower while someone is an inpatient. So an outpatient facility has a number of benefits to the patient, as well as to the insurance company and the employer, since it's much less expensive."

**Excerpted from *Drug Abuse: The Workplace Issues* (AMACOM 1987)

conduct health screening programs to identify persons who are potentially at risk, benefits managers give these programs very low ratings in terms of actual cost containment (see Exhibit 3.4).

Wellness initiatives can range from a smattering of health-related programs (quit smoking programs, lectures on health-related topics, hypertension screening) to a broad-scale, all-out effort, an approach that Bob Rosen of the Washington Business Group on Health calls a "healthy company" orientation (see "Healthy Company" section of this chapter). Most organizations, however, belong to the former category and lack an integrated approach.

We asked respondents to indicate which initiatives their companies used and to rate these for effectiveness in containing costs on a 1 (low) to 5 (high) scale. Our findings on this question follow:

**Screening for Hypertension/High Cholesterol
and Follow-up Support**
(percent using: 21; effectiveness: 3.3)

Targeted programs, such as hypertension screening, rank highest among our respondents

in effectiveness at containing costs (see Exhibit 3.4). Myrna Dinsmore, R.N., B.S.N., at the Life Extension Institute in New York City, reports that a recent health fair sponsored by Continental Airlines, in which her company was a participant, out of 300-odd persons screened, approximately 10 percent were detected as having high blood pressure. Spotting this "silent killer" would seem to offer substantial cost containment opportunities: screening is easily done and can avert potentially catastrophic illnesses in the form of stroke and cardiovascular disease.

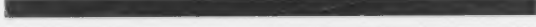
Testing for high cholesterol is not necessarily part of the bloodwork done by physicians during routine physical examinations. Screening for high cholesterol at the workplace can reveal abnormalities in blood levels that an employee may be unaware of.

On-Site Exercise Facilities
(percent using: 15; effectiveness: 2.75)

Cost savings resulting from employee use of worksite exercise facilities are hard to document. In addition, many employers report that participation rates are low.

The medical community wholeheartedly advo-

Exhibit 3.4. Average effectiveness ratings, various wellness initiatives (whole sample). Respondents used a 5-point scale to rate each program on its effectiveness in terms of health care cost containment. A 5 equals "highly effective."

Screening—hypertension high cholesterol		3.30
On-site exercise		2.75
Health education		2.88
Behavior modification		3.14
"Healthy company"		2.28
Employee assistance program		3.24

icates regular exercise as an important preventive measure against a wide variety of illnesses: exercise improves cardiovascular fitness thereby reducing the risk of coronary disease; it helps control weight and blood pressure and has a palliative effect on depression and stress.

Authors of Prentice-Hall's *Managing Employee Benefits* (1987) assert: "Proof positive that employee physical fitness programs are cost effective remains to be seen. But some results are emerging, and there seems to be cause for optimism." The publication cites Control Data's findings based on an evaluation of its Staywell program: a 36 percent reduction in health care costs and fewer hospitalizations for employees who participate in fitness programs for at least a year.

Health-Related Educational Programs (percent using: 40; effectiveness 2.88)

Health education programs receive a medium-to-low effectiveness rating. They are, however, one of the most frequently used initiatives.

Behavior Modification Classes (percent using: 41; effectiveness: 3.14)

Employed by 41 percent of the respondents, this initiative, for all intents and purposes, tied health education (40 percent) and EAPs (40 percent) for most frequently used. The workplace offers an ideal setting for behavior modification programs because of its built-in support system—employees who have been successful can offer encouragement to those who are still trying. Such programs are usually easy to arrange, often at no cost to the employer.

Public service ads tell smokers that quitting is the single most healthy thing they can do for themselves. According to Prentice-Hall's *Managing Employee Benefits* (1987), "Most cases of bronchitis and emphysema—the major

causes of disability retirement—are tied to cigarette smoking." The cost to employers of workers who smoke is high—up to \$4,000 a year more than nonsmoking workers, according to some estimates.

Organizations such as the American Cancer Society and the Lung Association conduct quit smoking programs at the workplace, free of charge. The American Cancer Society reports a 35 percent success rate (persons remaining cigarette-free after one year) with its program. The ACS also sponsors the Great American Smokeout, a "quit smoking" day held every November. Many employers have encouraged employee participation in the Smokeout through special promotional efforts.

Promoting good nutrition and weight control is another kind of targeted behavior modification effort that is often part of an employee wellness program. Costly illnesses such as diabetes and cardiovascular diseases are weight/nutrition related; these diseases take their share of employee benefits dollars. Programs can range from educational campaigns, including distributing informational literature, to improving the nutritional content of cafeteria foods, to promoting in-house weight reduction through such programs as Weight Watchers.

Weight Watchers has designed a special "At Work" version of its world-famous weight reduction plan; it is geared to the needs of working people. Linda Bruno, service system coordinator at WW headquarters says that the At Work program "tries to help people juggle work and leisure and other lifestyle issues that relate to diet and the working person." The program homes in on such dieting difficulties as eating out, eating at one's desk, or coping with worksite vending machines. In addition, the time frame for the sessions is adapted to workplace needs—either a lunch hour or shorter meetings of 45 minutes to an hour.

Stress management is also often a component of behavior modification efforts. Prentice-

Hall's *Managing Employee Benefits* (1987) reports that when stress is chronic, and employees are unable to use it constructively, "its side effects include greater absenteeism, lowered productivity, more accidents on and off the job, and higher medical bills. At its worst, stress lays the groundwork for deadly disease . . ." By learning relaxation techniques and skills for coping and improving interpersonal relations, employees learn to turn stress to their advantage thereby reducing or eliminating its harmful effects.

"Healthy Company" Programs
(percent using: 12; effectiveness: 2.28)

Dr. Robert Rosen of the Washington Business Group on Health offers a model for the "healthy company":

The healthy corporation differs dramatically from its unhealthy counterpart. The most profound difference is that the former promotes health and productivity together. In these companies, "peak performers" and "stress resistant" employees are viewed as corporate assets, and the company does all it can to maximize their physical and mental health. Health care benefits and wellness programs are created to promote employee health, and work conditions and management policies are designed to support that end.

Such companies emphasize:

- Work conditions that are relatively stress-free
- Opportunities for participation and decision making
- Comfortable and productive work relationships
- Opportunities for career growth
- Clear work roles

- Well-managed change
- A balance between work and leisure

However, only 12 percent use such an approach and those that do give "initiatives to deal with company environment and management style" as a means of containing health care costs the lowest effectiveness rating of all initiatives (2.28).

Employee Assistance Programs (EAP)
(percent using: 40; effectiveness: 3.24)

Employee assistance programs, which grew out of pioneering attempts to deal with alcoholism among workers, have expanded vastly and now include both drug and alcoholism counseling and treatment of stress-related problems. Forty percent of the respondents maintain EAPs, and the initiative ranks second in effectiveness, next to targeted screening programs.

EAPs, according to our survey, had the greatest cost effectiveness among small companies. Although only 18 percent use them, benefit managers from these companies give them an effectiveness rating of 3.75. This rating represents the highest for any initiative among companies of all sizes. It may indicate that in a small company, the impact of a single troubled worker is far greater than in a larger company, where one person's poor performance is more easily absorbed.

Conclusion

Wellness programs are, in general, large-company initiatives (see Exhibit 3.5). The primary deterrent to setting up such programs is lack of conviction regarding effectiveness. Few companies using a wellness approach have tracked cost savings over time. Indeed, one that has, Control Data, finds that such measures do have an impact. Longitudinal studies, using Control

Exhibit 3.5. Percentage of companies using wellness initiatives by company size.

	<i>Whole Sample</i>	<i>Number of Employees</i>			
		<i>Less than 500</i>	<i>500- 2,499</i>	<i>2,500- 5000</i>	<i>More than 5000</i>
Screening—hypertension/high cholesterol	21	8	25	34	25
On-site exercise	15	5	17	24	23
Health education	40	19	43	52	64
Behavior modification	41	23	45	52	56
"Healthy company"	12	10	12	21	12
Employee assistance program	40	18	37	69	58

Note: N = 323

Data's employees, show that wellness initiatives, when carefully managed, can result in reductions in visits to doctors' offices and hospitals. Targeted programs, such as hypertension screening and high cholesterol screening, are the most cost effective. Control Data has found.

MEASURING COST CONTAINMENT: CAN IT BE DONE?

Rare is the benefits manager who can point his finger at a clear cause-and-effect relationship. One is, after all, working in a real world where new elements come into play daily. Plan changes generally involve more than one component; changes may have come in successive years, blurring the impact of any single one.

To gain some insight into this issue, our researchers conducted interviews with 30 questionnaire respondents whose cost increases for the three-year period under study were less than for the other companies. We asked how they accounted for this performance. Could they cite any statistical evidence showing that a particular approach had taken hold?

About one-third of the respondents gave an-

swers that pointed to workforce demographics. Their employees were young (in their mid-30s), white collar professionals, and very healthy. "Every time I get the renewal statement, I expect a skyrocket," said one respondent. Her firm—an engineering consulting service with 400 employees—has had no change in rates for a three-year period. "We're doing everything we can to keep them healthy," said the respondent. "These are intelligent people, and they are responding to the education we provide. Our on-site aerobics classes may have something to do with keeping them healthy, but it's hard to say."

Fifteen of the 30 companies interviewed speculated that a combination of actions had proved effective. "I firmly believe that higher out-of-pocket expenses caused employees and families to evaluate self-health and health maintenance critically prior to doctor or hospital treatment," indicated the benefits manager from a service organization. "But the only evidence I can give is that our rates remained stable for a three-year period." The company introduced a \$200 individual deductible and a \$400 per-family deductible in 1984, moving the out-of-pocket maximum to \$600 for a single employee and \$1,200 for a family. The 1984 rate (minimum premium funding arrangement) remained stable; 1985 saw a one percent drop in the rate; 1986, no change. Then, in 1987, a

skyrocket: a 20 percent boost. Still, the four-year performance shows a cost profile well below that of the typical respondent.

A midsize publishing company based in the South enjoyed cost reductions in both 1985 and 1986. These immediate drops may have come, in part, from a strong utilization review system and other programs introduced in the early 1980s, explained the respondent. Then, when the July 1987 renewal came it revealed a startling 17.4 percent increase. The company subsequently implemented a package of changes: deductibles of \$200 per person, and \$600 per family, with a cap moving to \$1,000. Simultaneous with this came managed care provisions, with the carrier handling precertification and case management. "Our three-month experience (July-September) shows an immediate 9 percent decrease," said the respondent, the point being that the "package" of revisions proved more effective than changes made piecemeal. "The only problem," said the respondent, "is that we're catching a lot of flack about the deductibles."

Similar responses from the employees at a West Coast financial institution spurred successive changes in plan design. A move to self-insurance and subsequent elevations of deductibles brought a 32 percent decrease in 1985 costs. The victory was short lived, however, as employee complaints became intense and contribution rates climbed 17 percent over the next year. The following year saw the addition of flexible benefits as a way of dealing with employee morale. In 1987, the company moved toward managed care provisions and case management. Again, in response to employee morale, the company now offers three plans: a \$150 deductible, a \$500 deductible, and a \$1,000 deductible. Employee contributions for the most expensive of these climbed to \$105 per month for a family. All in all, the rate of increase broke even for the three-year period, the 1985 decrease being offset by increases of 17 percent and 12 percent in the subsequent years.

The benefits manager at a midwestern municipality firmly believes that a package of changes introduced in 1983 had a long-lasting impact—a rise of 11.5 percent in 1985 being subsequently offset by decreases in 1986 and 1987. "Since there have been no major changes in our workforce profile since 1983, I have to believe that the package worked—and that it may still be working. The 1983 changes involved mandatory second opinions, managed care provisions, case management, incentives for outpatient services, and reimbursement on the basis of reasonable and customary schedules. "I fully expect that our costs will go up," said the respondent, "but for now, we've been very fortunate."

This respondent expressed a high level of frustration because the organization handling precertification was not delivering activity data. "At the very least, I would expect to get information on how many reviews were conducted. Ideally, I want the number of denials and a projection of hospital dollars saved. I've pleaded with them for this information; they won't give it to me. It's been four years."

Our researchers followed up with questions to other respondents using outside sources for UR. Were they satisfied with the activity analysis being provided? Eight out of 10 expressed dissatisfaction. Either information was slow in coming or nonexistent. Although this should not be taken as a representative sample, it does point to a potential problem. (Note: similar comments occurred with reference to case management programs, as the next chapter shows.)

For several of the smaller company respondents, communication with employees greatly facilitated containment. One example, a food processor in California, recently experienced a stabilization of rates in 1986 and 1987—a big change over their 1985 increase of 19 percent. And this flattening occurred even with a change in carriers in 1987, and the addition of a large package of cost containment features. These

included mandatory second opinion, cafeteria benefits, managed care, case management, utilization review, and a whole host of hospital limitations. In fact, there was a one percent decrease in 1987. Secret for containment: communication.

To get across the idea of savings to employees, the benefits department conducts a communications program twice a year. The first part is an all-employee meeting, scheduled in November, on health cost containment. During this two to three hour session, both the benefit manager and a representative from the insurance carrier address the employees on what is available to them, and changes in policy. At this time, every employee receives a personalized itemization of their health care utilization, showing in dollars what health care costs him and the company. The idea of the personalized accounting came from an employee who had used it at another company.

The second communication comes during the company's second quarter, when there's a written personalized communication, showing each employee what his or her total benefits are. "We go over all the benefits and really drive home the cost containment idea," asserts their benefits manager.

For others in the small-company category, help from a trade association proved instrumental.

Companies that have joined a national association—essentially a multi-employer plan—are seeing major benefits. By combining with a large group, and through wellness programs (screening for hypertension), they have been

able to contain costs. One such company, a rural-based utility, experienced a 10 percent increase in 1987, but decreases in premiums over the previous two years, and a dividend/refund of 12½ percent of their total premium in 1987, put the firm well below the average.

According to the benefits manager, the advantage of joining the association is its ability to crack down on health care abuses by processing claims internally. This was especially successful in terms of chiropractic and podiatric cases. For chiropractic, "fixing something" is okay, but maintenance (regular visits) is not. For foot care, if surgery is needed, it is paid for. Again, routine foot care is not covered. Also, two key factors to these savings are connected to the company's makeup: the rural base of the population and the high-risk nature of the job. According to the benefits manager, the employees have "a mindset toward safety" that may be more intense than in other work situations.

We were also able to look more closely at the association, since it returned a questionnaire. The association experienced a decrease in health costs in both 1986 and 1987 of 5 and 10 percent, respectively. In addition, 1987 saw the inclusion of two new cost containment initiatives, managed care and case management programs. A move toward wellness programs was also instrumental in their savings. These included screening for hypertension/cholesterol, health education, behavior modification, and employee assistance programs for stress and drug/alcohol rehabilitation. These cost savings also occurred in spite of a trend toward decreases in the use of current HMO offerings.

4

Focus on Case Management

The buyers' caveat "You get what you pay for" has never been a guide for smart shoppers. Health care provisions under case management programs are a case in point. Here, high cost doesn't necessarily equate with quality; nor does low cost have to mean settling for less. According to one respondent to the AMA questionnaire, "It's the only program where we save money *and* get thank you letters from employees."

Enthusiasm for case management runs high among companies that have adopted the initiative. Of the 323 companies that sent in questionnaires, 144, or 45 percent, had introduced case management provisions for home and hospice care. Of these, 73 percent gave responses ranging from laudatory ("excellent") to satisfied ("effective" and "necessary").

The question was phrased: "Because a significant percentage of health care costs are incurred by persons with less than six months to live, a case management approach and/or broader provisions for covering home and hospice care may be an effective solution. Has your company had any experience with case management?" Respondents could answer:

- Yes, we have had claims under case management.

- Yes, we have had claims under provisions for home and hospice care, or
- No such experience

Respondents were then asked two open-ended questions: "If yes, what problems, if any, were encountered in implementing this coverage?" and "What is your opinion of such coverage, both in terms of humane treatment and cost containment?"

Fifty-two percent of the companies offering case management awarded the option stellar grades, saying they had encountered no problems, had contained costs—many dramatically—and that their employees had been more than satisfied with the treatment. Said one respondent, "Quality of care is improved; patient and family emotional levels are stabilized; the option offers tremendous cost control opportunity." And another stated, "We were able to return a paraplegic worker to full employment in our workforce."

Another 20 percent encountered some problems but still rated the program "highly successful" and "important," both in terms of cost containment for the company and optimal care for employees. Another 15 percent whose companies have adopted case management have not yet had claims under the provision

but expressed high hopes for its potential to both contain costs and offer quality care.

Another 6 percent have had no experience to date and made no comment, positive or negative. Finally, 6 percent either cited a problem but said nothing positive, or had reservations that seemed significant.

Since the questionnaire asked respondents to mention specific problems, we received more detail on this question than on the next question, "What is your opinion of such coverage, both in terms of humane treatment and cost containment?" To this, the response was often simply an expletive ("terrific") or a brief endorsement—"makes perfect sense for both reasons."

We will begin with discussion of the difficulties cited (those from the "some problems" group, but still highly positive, and the last group, the "negatives"). Problems were diverse, with the highest consensus (11 out of a total of 37 respondents) citing problems related to the provider, that is, a carrier or a case management or utilization review firm.

THE NEGATIVES

The reader must bear in mind that while a much greater proportion of space is devoted to discussion of problems, only 6 percent of the total respondent group were negative, and the remainder who cited problems all remained highly positive about the program. Focus on potentially problematic areas is intended to be instructive.

Resistance

Of the 37 respondents that mentioned problems, 7 cited resistance on the part of the employee (the patient) and/or family members. Some individuals regarded hospital care as su-

perior. Said one respondent, "Family members perceived hospital care as 'better care' and wanted to do everything possible for the relative. The patient had no financial incentive to leave the hospital, since our plan pays 100 percent." Despite this snag, the respondent rates case management "effective for cost containment and quality of care."

The patient's family represents a key component in the treatment picture. The opportunity for family members or significant others to be near is often emotionally therapeutic for the patient and an aid to recovery. However, caring for a severely ill person at home can be highly stressful for the care givers. If home care is the option chosen, experts agree that communication among all parties—case manager, family members, professional care givers, and physician—is vital.

For the terminally ill, home care is usually welcome; in AIDS cases the option is a definite "win/win." AMA's 1985 study *AIDS: The Workplace Issues*, asserts, "For many AIDS patients, home care is by far the preferred approach." The study goes on to quote Gerard Wagner of Bantam, Connecticut: "I recently cared for a terminally ill patient at my home. The three weeks of care cost \$1,200. The same care in a hospital would have cost \$21,000. During my friend's illness, we received wonderful support from a local hospice and from the service people who delivered our supplies."

At one self-insured company that administers the program in-house, employees tended to regard the case manager as a "company spy." The comment reflects some of the confidentiality issues that can accompany in-house programs. Because some employees are reluctant to disclose health-related problems to a benefits manager or other colleague, some experts recommend that case management be performed outside the organization only, either directly with a case management firm or via an insurer.

Effective communication of case management at the workplace, to all employees, is crucial in fostering a positive attitude toward the plan. The option should be visible, say insurance providers. Carriers will often play a significant role in communicating with employee groups about the new benefit. Sharing "success stories" with the workforce via a company newsletter or other means also gets the word around.

Communication stressing that employees are gaining an option, not losing a benefit, is also important. Because employees may feel that they *are* losing not gaining if case management is mandatory in some instances or for some procedures, voluntary programs are often viewed more favorably.

Problems with Insurers or Case Management (Utilization Review) Firms

All 11 respondents who mentioned problems with insurers or case management firms still gave the program high marks. Either the benefits outweighed the liabilities, or the problems were satisfactorily resolved. Interestingly, none of the "negatives" cited provider relations as a drawback. Apparently such issues are not serious enough to cause employers to reject case management.

Several respondents pointed to difficulties in obtaining data from the insurer or the case management firm. Any company contracting for case management may wish to check the organization's performance record and review cost/benefit and utilization figures. If the provider is forthcoming at this point, it is less likely that problems will arise in the future.

Some respondents felt that red tape prevented timely implementation of the treatment plan—the approval process took too long or they encountered problems in getting a go-ahead for a particular health care facility. Some of these problems may stem from overly rigid utiliza-

tion review requirements on the part of the case management service. Said one respondent, "[It] seemed difficult to verify the need for home health care; the firm was very strict about the length of time needed for recuperation." This respondent's opinion: "Great idea if it wasn't so difficult to get approval."

Quick approval is important, say our respondents: "The biggest problem is cutting through red tape in the approval process. At times, the patient goes without care until the approval is granted. Sometimes he dies before that time or just a few days later. Although I think case management is great, unfortunately, many of the providers are more interested in establishing financial ability to pay rather than focusing on the patients."

Because of the possibility of such serious eventualities, experts agree that approval procedures should be established before the program is launched. It is up to human resources managers or whoever is purchasing the plan to assure that the case management firm or insurer has timely and efficient approval mechanisms in place.

Optimal efficiency in implementing case management can only be achieved with a benefits plan that is flexible, say respondents. "Exceptions" are time consuming and inefficient for the insurer—the fewer the better. Indeed companies must be willing to go outside a benefits plan, but most options should be written in. One caution, however: limitations must also be written in. In this regard, one respondent commented: "We use case management as a means of working with the patient, making suggestions on alternatives that may be beneficial to all involved. Problem—How far do we go?" The respondent offered the following opinion: "[It] must be carefully controlled to prevent making this into an 'open checkbook' for granting exceptions." Many firms modify their benefits plans when initiating case management. Often the case management effort is part of an overall cost containment program in which the

entire health care benefits package is overhauled.

One respondent from rural Ohio found a dearth of adequate facilities (case management firms) in his region. Some providers, such as MONY Financial Services, contract with a case management firm (MONY uses The Health Data Institute, part of Baxter Health Care Corp.) that has case managers distributed over a large geographical area to serve a widely dispersed clientele. In this way, MONY has access to 600 case managers across the country.

The best case managers, according to Gavin Kerr, director of managed health care at MONY, "must have . . . the negotiating talent of an oil trader and the wisdom of Solomon." In addition to having protocols and "rules" up front, a firm has to select a case manager who is totally familiar with cost-efficiency methods and has close relationships with suppliers that enable him or her to negotiate advantageous discounts quickly. A good case manager has preestablished relationships with vendors in his or her geographical area, and often nationwide, to accomplish this goal.

Uncertainties About Cost Containment

Five respondents expressed uncertainty about the cost containment benefits derived from case management. One stated that hospice care, "although very humane, offered no savings."

In fact, data collected on actual cost/benefit ratios is scant. Services often offer individual case studies showing examples of costs and benefits. However, documentation on how employers have reduced the cost of catastrophic illnesses over time are rare indeed.

Case management has only recently come into fairly widespread use. For the most part, companies citing that they were not convinced as to cost savings had just recently set up provi-

sions and had had virtually no claims experience.

Another factor to bear in mind is that case management cost savings occur over time—paybacks are sometimes two to three years or more in coming. In some instances, short-term expense (for a top-notch rehabilitation facility, for example) can exceed costs for an acute care setting. However, over the long term, in such cases, savings resulting from early return to work, prevention of complications, and avoidance of disability payments can be significant.

Many factors in a home care or hospice program may impinge on cost effectiveness. Inadequate preadmission review, failure to communicate the plan to employees (who then do not self-refer when a serious illness occurs), and poor case management (failure to negotiate advantageous discounts, lack of knowledge about appropriate facilities, etc.) can all contribute to poor cost containment. One respondent states, "By the time [the employee and family members] got to case management, they had exceeded their out-of-pocket maximum and case management didn't have much leverage with them." The opinion in this instance was, "Humane treatment not impeded. But did not contain costs." Preadmission review and the utilization review activity inherent in good case management are actually a built-in assurance of cost efficiency.

Absence of an efficient precertification program (to flag the cases up front) led to problems in four instances. (One of these respondents merely urged attention to the necessity of preadmission review.) In one company, poor up front flagging accounted for the failure of case management in the single claim it had had.

Liability

Three respondents, separately, cited confidentiality, liability, and legal issues as stumbling

blocks. One caution: state laws usually emphasize that utilization data cannot be used to penalize an employee for high usage, or in a manner that is in any way discriminatory, as in the case, say, of an employee with AIDS.

Lack of Cooperation from the Physician

Only two respondents cited physician cooperation as a problem. In one case, the doctor failed to call in to obtain precertification clearance. As the medical community becomes more familiar with case management, recognition of the benefits it can provide, both to the physician and the patient, is growing. Not only does a case management program offer more treatment options to the physician, but it also provides documentation for him or her in the event of a legal dispute.

BENEFITS

As mentioned previously, because of the wording of the question, respondents were not encouraged to embellish on the chief benefits of case management—humane care for the patient and significant cost containment. They did, however, dramatically affirm them.

Of the 144 companies that adopted case management, 103 voted a vigorous "aye." The unambiguous naysayers numbered only 9, with our researchers stretching in their efforts to be conservative.

Survey respondents and other commentators stressed the following additional gains derived from a case management program:

Goodwill

Employee satisfaction is no small "plum" for an employer. To quote one respondent, "Case

management promotes goodwill between employee and employer. Willingness to go outside plan provisions shows that the employer places a high priority on providing the best treatment." In speaking about employee satisfaction, an insurance carrier affirms the effect of goodwill: "When your employee benefits plan helps somebody in crisis, that can't help but pay off in terms of your employees' satisfaction with the plan and their loyalty to the organization."

Other Cost Containment Features

Catastrophic illnesses are classically mismanaged. Often several doctors, whose communication with one another may be minimal, are treating the patient for different aspects of an illness. By coordinating and monitoring care and facilitating communication, the case manager is aware of the whole picture in a way that no one else may be. He or she can help prevent duplication of tests and procedures. In addition, as an expert in various treatment alternatives, which the primary care physician may not be, the case manager is instrumental in reducing the possibility of complications. By getting a patient the best care at the most appropriate facility, he or she can often effect a speedier return to work for the employee, thereby reducing or eliminating long-term disability payments. Says one respondent, "Case management not only seeks out more cost-effective treatment but generally assists the patient in a faster return home."

Utilization Review

As mentioned earlier, the best case management approaches, in effect, perform utilization review. Says one respondent, "It enables monitoring of claims on a concurrent basis." This feature is also a cost saver.

Early Intervention

Up-front flagging or precertification enables the case management team to enter the picture early on. Several respondents stressed the importance of preadmission review in this regard. It does, indeed, achieve the earliest intervention. The sooner intervention occurs, the better the patient's prognosis and the greater the cost savings potential.

Outpatient Benefits

Many procedures that once called for hospitalization can now be done on an outpatient basis

because of new technologies and other medical innovations. Case management allows outpatient coverage, often not available in conventional plans.

Psychiatric cases in particular place a huge strain on the health care dollar. In this area, outpatient care is often highly appropriate. Said one respondent, "We have used case management mostly in connection with mental health cases. Occasionally, [psychiatric] hospitals appear to keep patients until limits are reached. [By contrast] such patients like outpatient care and accept it. We have found effective cost containment in large cases."

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